While some uninsured patients are being enrolled in the D.C. Healthcare Alliance and receive prescription drugs through that program, it appears that this portion of the Alliance may not have been sufficiently funded, and could be an additional source of unmet pharmaceutical needs in the District.

Finally, the city suffers from a lack of organized support for private-sector health insurance. The District is one of the few medium- or large-size cities nationwide without a business health-care coalition. It has no organized purchasing cooperative to make health insurance more affordable for small businesses. It lacks a high-risk pool to assist those who are otherwise "uninsurable." There is no fallback "standard plan" for individuals who cannot afford to buy coverage on their own, as there is in Maryland and other states. The lack of these private-sector supports will exacerbate the access problems of significant numbers of people leaving welfare for work in the near future because they have exhausted their time limits under the Temporary Assistance to Needy Families (TANF) program.

Despite these gaps and flaws, the District's health system has some strengths on which to build. There are premier teaching institutions conducting path-breaking research. The health centers are mobilizing to strengthen the primary care delivery system. There are countless medical groups with experienced physicians. Managed care organizations are working on improving preventive care and disease management. Community groups such as the Marshall Heights Community Development Organization are working to promote better access to care for people in under-served neighborhoods. Foundations are investing in improving health care delivery to vulnerable populations. These resources need to be better organized and coordinated.

On the other hand, Washington, D.C. has relatively few foundations whose missions and activities are local in nature, as compared to other cities of its size and vitality. This new foundation would not only be the first foundation established since the early 1990's that was dedicated to the health and well-being of its residents, it would be one of the largest of its kind in the District.

In summary, while the District has an ample *overall* supply of health care resources, the trained personnel and facilities are very unevenly distributed throughout the city and inefficiently managed. The system is very expensive, and yet many are under-served. A newly formed foundation will have an important opportunity to contribute to the improvement of health care in the District of Columbia.

POLICY OPTIONS

We have identified five policy options that could alleviate the problems enumerated above and improve the health of the residents of the District. Moreover, each policy option would provide the foundation with a number of opportunities to help the District pursue these policy options, either by funding a program directly or more likely by underwriting technical assistance, planning, research and other related activities in support of program efforts. The options presented below comprise a menu of opportunities to improve access to care and health outcomes.

I. COVERAGE EXPANSION

Promote Enrollment in Medicaid and S-CHIP

Improving health will require reducing the number of uninsured. A good starting point is to facilitate greater enrollment of adults and children who are already eligible for either S-CHIP or Medicaid. In the District, children and adults are eligible for these programs if they live in households with incomes below 200 percent of the federal poverty line (FPL). According to one study of the District's residents, about 30 percent of District residents with incomes below this level were uninsured, compared to only 5 percent with incomes above this level. Indeed, according to this 1998 study, about 66,000 of the then-estimated 81,000 uninsured in the District had incomes less than 200 percent of the FPL.[10] (As noted earlier, a more recent study estimated that the number of uninsured in the District dropped to about 72,000 in the 1999-2000 period. Because of a sluggish economy since that time, however, it seems likely that the number of uninsured has drifted upward again.)

Of the 66,000 uninsured with incomes less than 200 percent of the FPL, about 18,000 adults and children were already eligible for S-CHIP or Medicaid (because they meet the other eligibility requirements, namely, families with children, elderly and disabled). A foundation could target these 18,000 for outreach to improve enrollment. The District has been active in trying to expand enrollment within this group. It has used such measures as presumptive eligibility (sign up now if believed eligible, verify later), out-stationing of workers to neighborhood locations, and waiver of asset tests. But more could be done in this area.

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[10] The Lewin Group, Inc. "A Plan to Expand Coverage under Medicaid in the District of Columbia." Prepared for the D.C. Department of Health, Medical Assistance Administration, March 17, 1999.

Another important opportunity involves *extending coverage to low-income adults who currently are not eligible because they do not have children.* More than 38,000 adults with incomes less than 200 percent of the FPL were determined to be uninsured and without dependent children--thus, despite being deemed lower-income, they were ineligible for Medicaid.[11] While children living in poverty are now automatically eligible for Medicaid under federal law, states and the District can only obtain federal Medicaid matching funds for adults without dependent children by receiving a waiver from the United States Department of Health and Human Services (HHS). The District has received a waiver to start this process by extending Medicaid coverage to adults without dependent children who are 50-64 years old. Approval of the waiver took a long time, and implementation of this new pilot program has been slow.

A related challenge is to work with people losing cash assistance under TANF who are eligible for, but not participating in transitional Medicaid coverage. Under the 1996 welfare reform law, people who lose cash assistance may still be eligible for Medicaid for at least a year, and some states have increased this to two years. But women with children frequently are unfamiliar with this coverage, and often take jobs with no employer-sponsored coverage and remain uninsured.

Possible fundable activities:

- To facilitate enrollment of Medicaid and S-CHIP eligible adults and children into public programs (including transitional Medicaid), the foundation could *support outreach and enrollment activities*, such as sponsoring enrollment fairs at schools, funding an enrollment facilitator at local clinics, or helping develop family resource centers. This may be a good opportunity for the foundation to partner with other foundations already doing work in this area such as the Robert Wood Johnson Foundation's Covering Kids program.

- To extend eligibility to adults who currently lack it, the foundation could *provide support for technical assistance* to help with the implementation of the new HHS waiver. This might include tracking and evaluation that could lead to program adaptation and improvements, and a learning curve that would assist later expansions.

Expand Private Sector Coverage

While improvements in public programs are important, the reality is the city probably could not afford to cover all the uninsured. If everyone with incomes below 200 percent of the FPL were

[11] Mayor Anthony Williams' Health Insurance Expansion Plan, March 28, 1999.

enrolled in Medicaid, more than a third of the residents of the city would be participating in this program--an unlikely outcome with significant costs for the city. Therefore, efforts to bolster Medicaid and S-CHIP enrollment should be accompanied by initiatives to support employer-based and other private coverage.

The following list outlines some strategies to encourage private coverage, starting with a list of policy measures designed to lower the cost of coverage and then discussing how subsidies might further encourage private market coverage. The following list of policy options includes some long-term strategies and some strategies that would help address the District's immediate needs. If the foundation chooses to fund initiatives that would focus on expanding private sector coverage, it should work with local policymakers since many of these options would require new District legislation. This section is intended to outline some of the options that local policymakers might pursue. *The role of the foundation generally would be to support work around developing these options, rather than underwriting the cost of the expansion itself.* Fundable activities are listed at the end of this section.

High-risk pools. A number of states have formed "high-risk pools" to offer coverage to people who are priced out of the regular private non-group health insurance market. These are people who are, in effect, uninsurable, not because they will not be offered coverage (federal law requires insurers to offer coverage under certain circumstances such as when people leave a job with employer-sponsored coverage and attempt to buy insurance on their own), but because the premium is well beyond their reach. This occurs when people have some combination of low incomes and known health conditions that create a high probability that they will use a lot of health services in the near future.

High-risk pools enable people to get coverage with premiums that cannot exceed some set amount above the average in their region (e.g., 150 percent of this average). This insurance, however, is usually subject to a substantial deductible, exclusions of certain health services that are normally included in regular insurance, and higher premiums even with the caps. These features of the coverage in high-risk pools make this option unattractive for many people with high health risks. In many states, only 1 or 2 percent of those who are eligible to participate actually do so.[12]

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[12] Achman, Lori and Deborah Chollet. *Insuring the Uninsurable: An Overview of State High-Risk Pools.* The Commonwealth Fund, publication # 472, August 2001.

Opening up public employee insurance pools. One possibility is to allow District residents who buy health coverage on their own and those in small firms (e.g., 2-50 employees) to buy into the Federal Employees Health Benefits Program (FEHBP), a change that would require federal legislation. There is already a precedent for this as the D.C. public school teachers are currently eligible for FEHBP. Alternatively, the city could open up the health benefits program for its own workers to these groups. There is concern on the part of city workers that this would raise premiums. However, this concern could be addressed by building a "firewall" between the new entrants and the city workers, essentially creating a separate risk pool within the program. Alternatively, the city could develop a parallel program that is an FEHBP "look-alike," but has a totally separate structure.

Purchasing cooperative for smaller companies. The District has many small firms--it is not a city dominated by large industrial companies. There are some very small-scale associations through which some small firms can obtain health coverage (e.g., the Chamber of Commerce), but enrollment is small, and these groups do not necessarily adhere to the practices of large cooperatives in such areas as guaranteeing that all firms and workers may participate, regardless of underwriting.

The new foundation may want to survey the numerous purchasing cooperatives that have been tried around the country to discover the ingredients of success and the primary barriers. A number of the cooperatives have either languished at a very small scale or failed. A few have become sustainable and viable.[13] What makes the difference? Could the District develop such a purchasing vehicle that molds the best features of successful approaches around the country?

Reinsurance. Under this approach, the government underwrites health care outlays per patient above some "catastrophic" limit. This helps encourage health plans to offer coverage in situations that they might otherwise consider too risky. In New York State, the government has developed a plan that pays 90 percent of the claims per patient in the range of $30,000 to $100,000. Individual premiums, employer contributions, and patient cost sharing help fund this program for people with incomes under 250 percent of the FPL. Reinsurance programs are also being used in New Mexico and Arizona.[14]

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[13] Wicks, Elliot K., Mark A. Hall, and Jack A. Meyer. *Barriers to Small-Group Purchasing Cooperatives: Purchasing Health Coverage for Small Employers.* Washington, D.C.: The Economic and Social Research Institute, March 2000.

[14] Silow-Carroll, Sharon, Emily K. Waldman, and Jack A. Meyer. *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs.* New York, New York: The Commonwealth Fund, publication # 445, February 2002.